



REHABILITATION SERVICES

REHABILITATION SERVICES
PRESCRIPTION

McLaren Rehab Services Jolly Rd
3394 E. Jolly Rd.
Suite B – Lower Level
Lansing, MI 48910
517/975-3520
517/975-3525 Fax

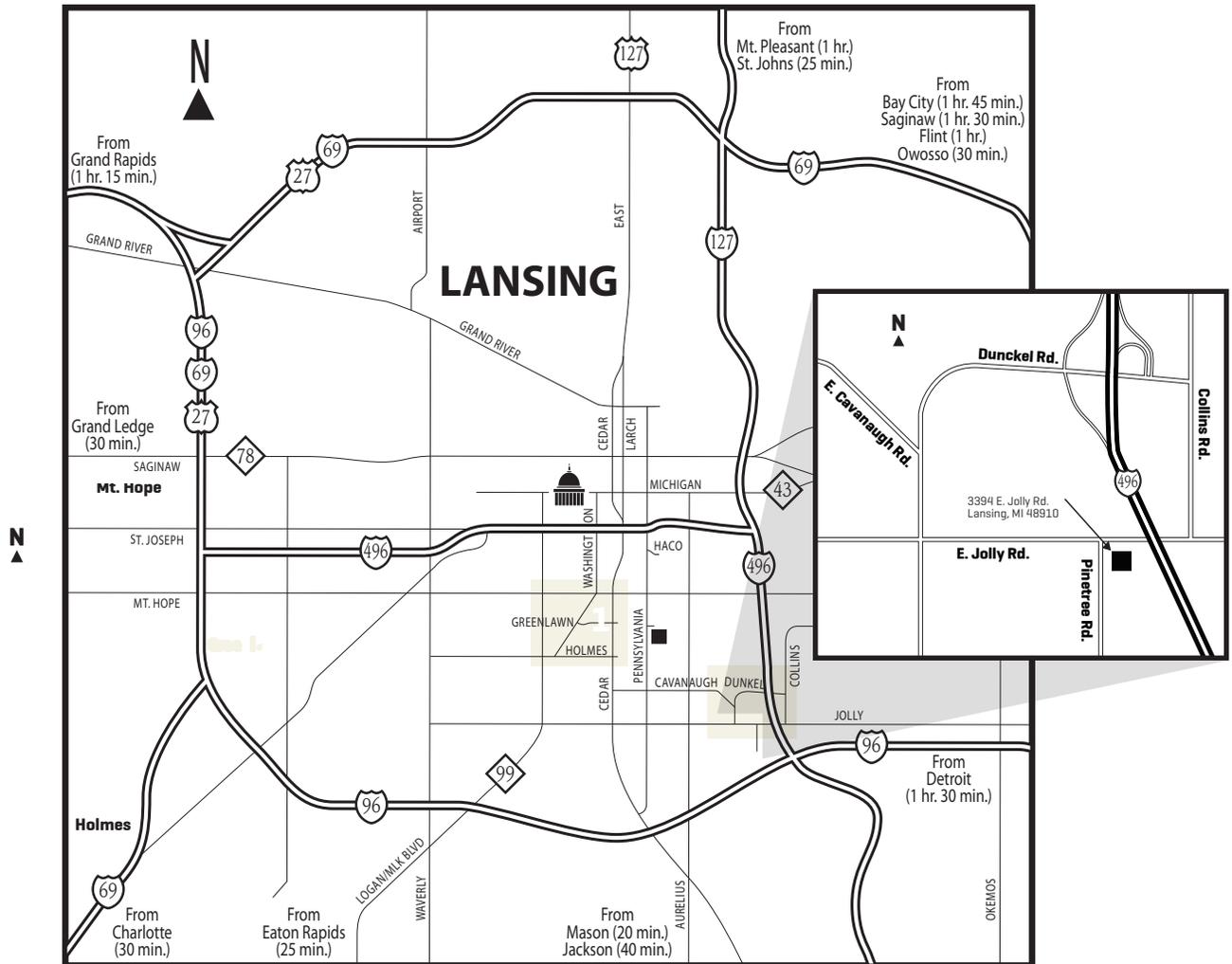
Patient:	Diagnosis:	
DOB:	Frequency: _____ times per week	
Contact Phone:	Duration: _____ weeks	
Surgery:	Time Period Covered: _____ to _____	
Special Instructions/Precautions:		
OCCUPATIONAL THERAPY		
<input type="checkbox"/> Evaluate patient, develop a plan of care, and implement plan in place	<input type="checkbox"/> Functional Activity	<input type="checkbox"/> Hot/cold packs
<input type="checkbox"/> ROM	<input type="checkbox"/> Desensitization	<input type="checkbox"/> Electrical Stimulation
<input type="checkbox"/> Strengthening	<input type="checkbox"/> Scar management	<input type="checkbox"/> Fluidotherapy
<input type="checkbox"/> Edema Control	<input type="checkbox"/> Coordination	<input type="checkbox"/> Paraffin
<input type="checkbox"/> Mobilization	<input type="checkbox"/> ADL Training	<input type="checkbox"/> Ultrasound
<input type="checkbox"/> Home Ex Program	<input type="checkbox"/> Neuro Rehab	<input type="checkbox"/> Other:
<input type="checkbox"/> Iontophoresis: Dexamethasone Sodium Phosphate 4mg/ml <input type="checkbox"/> Iontophoresis: Other (specify): _____		
<input type="checkbox"/> Splint Fabrication: _____		
PHYSICAL THERAPY		
<input type="checkbox"/> Evaluate patient, develop a plan of care, and implement plan in place	<input type="checkbox"/> Mobilization(joint)	<input type="checkbox"/> Home Exercise Program
<input type="checkbox"/> Passive ROM	<input type="checkbox"/> Strengthening	<input type="checkbox"/> Plyometrics
<input type="checkbox"/> AROM/AAROM	<input type="checkbox"/> Soft Tissue Mob	<input type="checkbox"/> Ultrasound
<input type="checkbox"/> Myofascial Release	<input type="checkbox"/> Balance/Proprioception	<input type="checkbox"/> Hot/cold pack
<input type="checkbox"/> Gait Training	<input type="checkbox"/> Postural Training	<input type="checkbox"/> Mech. Traction
<input type="checkbox"/> Manual therapy	<input type="checkbox"/> Taping	<input type="checkbox"/> Electrical Stim
<input type="checkbox"/> Unweighting	<input type="checkbox"/> Group Therapy	<input type="checkbox"/> Other:
<input type="checkbox"/> Iontophoresis: Dexamethasone Sodium Phosphate 4mg/ml <input type="checkbox"/> Iontophoresis: Other (specify): _____		
<input type="checkbox"/> Orthotics: <input type="checkbox"/> Custom <input type="checkbox"/> Temps <input type="checkbox"/> Refurbishment _____		

Physician Signature:	Date:
Physician (printed):	

Please Note: To ensure uninterrupted care for your patient, please sign and return this prescription for physical therapy/occupational therapy services to us by: _____.



McLaren Rehabilitation Services



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Our staff provides physical therapy services to a wide variety of injured workers and general orthopedic and post-surgical outpatients. The goal is to decrease work days lost, and a return to, or improvement of prior functions. This site also serves women's health issues, such as post-op breast cancer-related lymphedema and incontinence/pelvic pain.

Therapists also specialize in hand and upper extremity occupational therapy. Patient education, treatment of cumulative trauma, orthopedic disorders, and post-surgical rehabilitation are all provided at this clinic.